STATE OF UTAH INSURANCE DEPARTMENT

REPORT OF EXAMINATION

OF

IHC HEALTH PLANS, INC.
OF
SALT LAKE CITY, UTAH

AS OF

DECEMBER 31, 2002

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January 5, 2004

Honorable Merwin U. Stewart, Commissioner
State of Utah Insurance Department
State Office Building, Room 3110
Salt Lake City, Utah 84114-6901

In accordance with your instructions and in compliance with Utah Code Annotated (U.C.A.) Title 31A, an examination of the financial condition and business affairs of

IHC Health Plans, Inc.
Of
Salt Lake City, Utah

a nonprofit Health Maintenance Organization ("HMO"), hereinafter referred to as the Organization, was conducted as of December 31, 2002.

SCOPE OF EXAMINATION

Period Covered by Examination

The Utah Insurance Department's ("Department") last financial examination of the Organization was conducted as of June 30, 1998. The current examination covers the period from July 1, 1998, through December 31, 2002, including any material transactions and/or events occurring subsequent to the examination date noted during the course of the examination. The Organization's wholly owned subsidiary, IHC Benefit Assurance Company, Inc., was examined concurrently.

Examination Procedure Employed

The examination included a general review and analysis of the Organization's operations and a determination of its financial condition as of December 31, 2002. The examination was conducted in accordance with standards prescribed in the National Association of Insurance Commissioners ("NAIC") Financial Condition Examiners Handbook, NAIC Accreditation Standards and Department policy. It included tests of the accounting records and a review of the Organization's affairs and practices to the extent deemed necessary. Permitted assets and required liabilities were valued in accordance with laws, rules, and procedures prescribed by the State of Utah.

The Organization retained the services of a certified public accounting firm to audit its financial records for the period under examination. The firm provided requested working papers prepared in connection with its audits. The firm's working papers were given consideration in adoption of the examination plan and procedures, but did not significantly affect the nature and extent of examination procedures performed. The firm's correspondence regarding pending or

threatened litigation, claims, and assessments received from the Organization's legal representatives was relied on.

A letter of representation certifying that management has disclosed all significant matters and records was obtained from management and has been included in the examination working papers.

Status of Adverse Findings, Material Changes in the Financial Statement, and Other Significant Regulatory Information Disclosed in the Previous Examination

The previous examination increased reported net worth by $9,505,246. The increase resulted primarily from an increase in premiums receivable of $2,675,021 and a decrease in claims unpaid of $7,218,000. Several other immaterial adjustments were made to various accounts. This examination decreased claims unpaid by $11,621,297. The Organization's certified public accounting firm noted that claims paid subsequent to year-end, through October 31 of the following year, as a percentage of prior year reserves ranged from 49 percent to 70 percent for the years ending December 31, 1992, through December 31, 2001. The Organization has addressed other items of significance noted in the prior examination report.

HISTORY

General

In 1975, the Church of Jesus Christ of Latter-day Saints transferred all assets and liabilities of its hospital system to a board of trustees. The trustees in turn created Intermountain Health Care, Inc., a nonprofit corporation, to own and operate the hospital system. In 1982, IHC Hospitals, Inc., subsequently named IHC Health Services, Inc., was established as a subsidiary of Intermountain Health Care, Inc. for the purpose of operating the hospital holdings.

Intermountain Health Care, Inc. incorporated the Organization, under the provisions of the Utah Nonprofit Corporation and Cooperative Association Act, on December 27, 1983, for the purpose of developing and administering financial mechanisms for its network of health care services. The Organization began operations as a nonprofit preferred provider organization. On December 6, 1985, the Organization was licensed as an HMO. In 1985, the Organization formed and became the sole member of IHC Care, Inc. ("Care"), a nonprofit HMO. In 1991, the Company formed and became the sole member of IHC Group, Inc. "("Group"), a nonprofit HMO. Care and Group were merged into the Organization in 2000. In 1992, the Organization formed a wholly owned for-profit life insurance company, IHC Benefit Assurance Company, Inc.

The Organization was originally issued a Third Party Administrator's ("TPA") license to administer life and accident and health insurance on September 1, 1984. The license lapsed on September 30, 2000. On January 12, 2001, the license was reactivated. As of the examination date, the Organization was administering uninsured accident and health plans.

U.C.A. § 31A-8-106 does not allow the Organization to engage, directly or indirectly, in any business other than that of an HMO and business reasonably incidental to that business. The

TPA business, as conducted by the Organization, is considered by the Department to be reasonably incidental to the Organization's HMO business. Therefore, the Organization was in compliance with this section of the insurance code.

Copies of Amended and Restated Articles of Incorporation and Amended Bylaws were filed with the Department on July 11, 2000. On December 13, 2000, the Department approved the Amended and Restated Articles of Incorporation. The corporate documents were filed in follow-up to exceptions noted by a prior examination.

In 1999, the Internal Revenue Service ("IRS") revoked the Organization's tax-exempt status under Internal Revenue Code ("IRC") § 501(c)(3) retroactive to January 1, 1987, and issued final adverse rulings denying tax-exempt status to Care and Group under IRC § 501(c)(3) retroactive to January 1, 1994. In July 2001, the United States Tax Court denied the organizations' petitions for declaratory judgments of their tax-exempt status. On April 9, 2003, the United States Court of Appeals for the Tenth Circuit issued its opinion in which the court affirmed the decisions of the United States Tax Court.

In addition to applying for tax-exempt status under IRC § 501(c)(3), the organizations applied for IRC § 501(c)(4) exemption. In 1999, the IRS denied IRC § 501(c)(4) exemption to Care and Group. However, they reapplied for IRC § 501(c)(4) exemption in 2001. The applications for IRC § 501(c)(4) exemption for the organizations are under consideration by the IRS National Office. The law firm retained by the Organization believes that there is a reasonable likelihood the IRS may grant IRC § 501(c)(4) exemption to the Organization prospectively and retroactively for all open years. In addition, the IRS may reconsider its denial of exemption to Care and Group. On its own behalf and as successor in interest to Care and Group, the Organization has filed protective claims for refund of taxes paid, which will enable it to file refund actions in federal court in the event the IRS denies the applications for IRC § 501(c)(4) exemption.

In addition to federal income taxes, penalties, and interest paid, the Organization accrued a contingent income tax liability of $13,300,000. If the Organization is unsuccessful in qualifying for tax-exempt status for any of the three organizations, the Organization estimated that its exposure to loss in excess of the amount accrued was approximately $13,600,000 as of December 31, 2002.

Membership

The sole member of the Organization is Intermountain Health Care, Inc., a Utah nonprofit corporation, which has the authority to exercise all property, voting and other rights, interests, and powers of membership conferred by the Utah Insurance Code and the Utah Nonprofit Corporation and Cooperative Association Act to the extent applicable.

Intermountain Health Care, Inc., by board resolution, resolved that it "will continue to commit to provide IHC Health Plans, Inc. with loan guarantees or direct financing sufficient to enable IHC Health Plans, Inc. to meet all of its financial obligations." The following schedule presents capital contributions made by Intermountain Health Care, Inc. to the Organization since its inception.

Year	Amount
1984-1985	$ 2.750.000
1986	3.950.000
1987	1.550.000
1988	2.150.000
1989	2.000.000
1990	100,000
1992	17,625,275
Total Contributions	$ 30,125,275

The amounts identified as capital contributions from 1984 through 1989 were originally reported as donated capital by the Organization. The 1990 amount was transferred from a write-in item reported on the 1989 Annual Statement and earlier annual statements as "Statutory Reserve". In March 1992, Intermountain Health Care, Inc. issued a "Certificate of Contribution to IHC Health Plans, Inc." in the amount of $30,125,275.

Dividends to Member

No dividends were declared or paid during the examination period. Article XI of the Amended and Restated Articles of Incorporation states that no part of the net earnings of the Organization shall inure to the benefit of or be distributable to its member, trustees, officers or other private individuals, except that the Organization may pay reasonable compensation for services rendered and make payments and distributions in furtherance of the purposes set forth in Articles III.

Management

The Organization's Amended Bylaws state that the number of trustees shall not be less than four or more than thirty persons, as determined from time to time by the member. Trustees serving on December 31, 2002, were:

Name and Residence	Principal Occupation
Richard J. Galbraith, Chair Sandy, Utah	Retired. Former President of the Benefit Division, Fred S. James Company
N. Patricia Freston, Vice-Chair Salt Lake City, Utah	Vice President of Human Resources, N P S Pharmaceuticals, Inc.
Everett N. Goodwin, Jr., Secretary Salt Lake City, Utah	Senior Vice President and Chief Financial Officer, Intermountain Health Care, Inc.
Teresa Beck Salt Lake City, Utah	Retired. Former President, American Stores Company

Daniel E. England Sandy, Utah	Chief Executive Officer, C.R. England, Inc.
David H. Jeppson Toquerville, Utah	Retired. Former Executive Vice President, Intermountain Health Care
Edward G. Kleyn Ogden, Utah	President Northern Utah Southwest Wyoming, Wells Fargo Bank
Linda C. Lockman, M.D. Salt Lake City, Utah	Vice President and Chief Executive Officer Physician Division, Intermountain Health Care, Inc.
Henry L. McDermott South Jordan, Utah	Owner, McDermott Company and Associates
Thomas B. Morgan Sandy, Utah	Executive Vice President Retail Credit, Zions First National Bank
William H. Nelson Salt Lake City, Utah	President and Chief Executive Officer, Intermountain Health Care, Inc.
Harold D. Norton Provo, Utah	President and Chief Executive Officer, Far West Bank
Sidney C. Paulson Salt Lake City, Utah	President and Chief Executive Officer, IHC Health Plans, Inc.
Hugh G. Pearson Kaysville, Utah	Vice President, Intermountain Health Care, Inc.
Carl E. Ramnitz Sandy, Utah	Vice President Human Resources, Geneva Steel
Charles W. Sorenson, Jr. M.D. Salt Lake City, Utah	Senior Vice President, Intermountain Health Care, Inc.
Stephen D. Taylor M.D. Salt Lake City, Utah	President, Wasatch Emergency Medical Group

Board committee members as of December 31, 2002, were:

Executive Committee	Finance Committee
Richard J. Galbraith, Chair	Teresa Beck, Chair
Everett N. Goodwin, Jr.	David H. Jeppson
Sidney C. Paulson	Edward G. Kleyn
	Harold D. Norton
	Sidney C. Paulson
	Todd D. Trettin. *

Audit Committee	Quality Assurance Committee
Teresa Beck, Chair	N. Patricia Freston, Chair
David H. Jeppson	Henry L. McDermott
Edward G. Kleyn	Hugh G. Pehrson
Harold D. Norton	Carl E. Ramnitz
	Stephen L. Barlow, M.D. *

Appeals Committee

Sidney C. Paulson, Chair	Thomas B. Morgan
Daniel E. England	Cherie Brunker, M.D. *
Patrice Arent *	Morris D. Linton *
Stephen D. Taylor, M.D.	John T. Nielsen *

* Not a Board Member

Officers serving the Organization as of December 31, 2002, were:

Officer	Office
Sidney C. Paulson	President
Stephen L. Barlow	Vice President/Chief Medical Officer
Jerry R. Edgington	Vice President
Lisa K. Fallert	Vice President and Secretary
David H. Olson	Vice President
Todd D. Trettin	Vice President/Chief Financial Officer and Treasurer
J. Murphy Winfield	Vice President

Conflict of Interest Procedure

The Organization has a formal conflict of interest policy that requires that no trustee, director, officer, or employee use his or her position or any knowledge gained as the result of his or her position, in any manner such that a conflict does or may arise between the Organization's interests and his or her personal interests.

All trustees and four of seven officers filed signed conflict of interest disclosure statements in 2002. Beginning in 2002, officers of the Organization were not required to file conflict of interest statements. The requirement that officers file conflict of interest statements was reinstated in 2003 and in September 2003 the officers filed statements. Filed statements acknowledge that the officer or trustee understands the Organization's conflict of interest policy. In the filed statements, each officer or trustee agreed not to engage in any personal or business activity, which will create an actual or potential conflict of interest without first obtaining approval from the Organization. In addition, each officer or trustee was requested in the statement to disclose any personal or corporate business relationships that he or she currently has with the Organization or which may conflict with those of the Organization. None was disclosed.

Corporate Records

Annual statement general interrogatory number 12 erroneously reported that the Organization keeps a complete permanent record of the proceedings of its board of directors and all subordinate committees. Quality Assurance Committee meeting minutes were not kept as required by Article V of the Organization's Amended Bylaws.

In general, board of trustee and committee minutes indicate that the board and its committees adequately approved and supported the Organization's transactions and events. A notable exception was the authorization of salaries. There was no indication in the minutes that the board or a subcommittee took any actions with regard to compensation of trustees, officers or employees. In accordance with U.C.A. § 31A-2-204(8), the Organization promptly furnished a copy of the prior Department examination report to each member of its board.

Acquisitions, Mergers, Disposals, Dissolutions and Purchases or Sales through Reinsurance

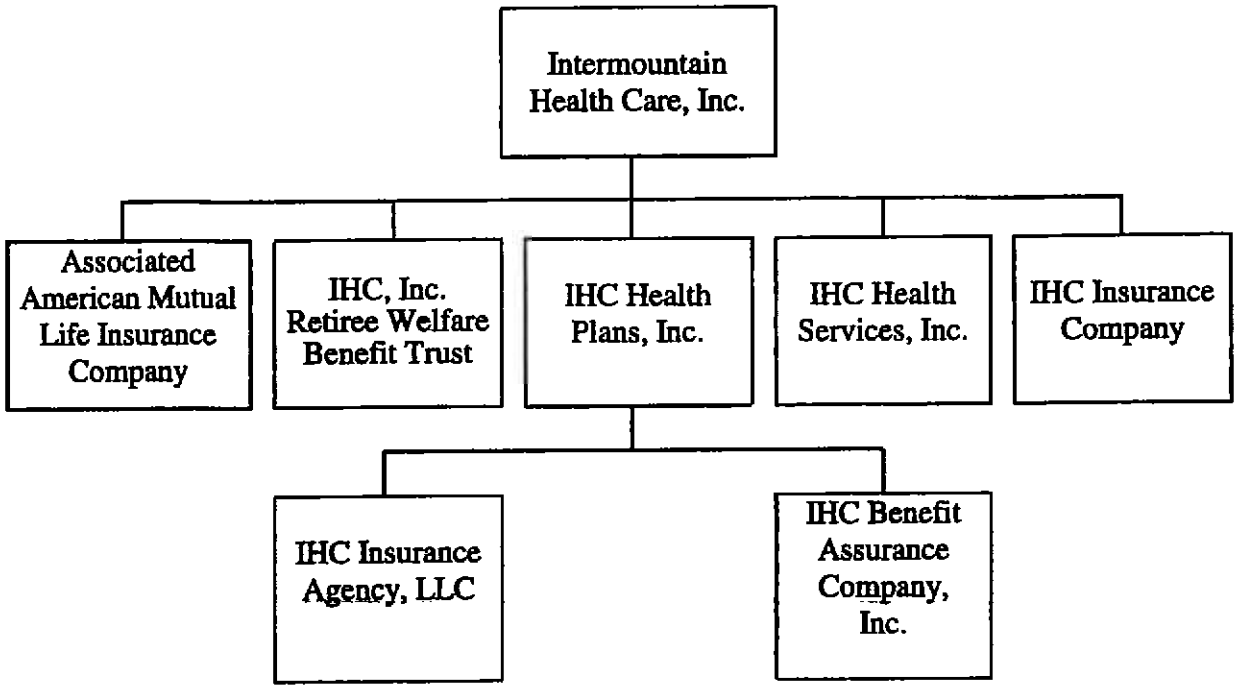
Care and Group merged with and into the Organization pursuant to Articles of Merger, dated October 20, 2000, approved by the Department.

Surplus Debentures

In 1998, IHC Benefit Assurance Company, Inc. issued a surplus debenture in the amount of $2,500,000 to the Organization. The debenture was retired in 2002. No surplus debentures were outstanding as of the examination date.

AFFILIATED COMPANIES

The Organization is a member of an insurance holding company system as shown in the following abbreviated organizational chart derived from Annual Statement, Schedule Y as of December 31, 2002.



The Organization is affiliated with numerous entities within the insurance holding company system. Many of these entities were not reported on Annual Statement, Schedule Y, Part 1 or in Form B filings with the Department, but should have been. NAIC Annual Statement Instructions for Schedule Y, Part 1 require "a chart or listing presenting the identities of and interrelationships between the parent, all affiliated insurers and reporting entities and other affiliates". A non-insurer need not be shown if it does not have activities reported in Schedule Y, Part 2 and its total assets are less than one-half of one percent of the total assets of the largest affiliated insurer or reporting entity. U.C.A. § 31A-16-105(2)(b) requires that Form B contain the identity and relationship of every member of the insurance holding company system.

Intermountain Health Care, Inc. is a Utah nonprofit charitable corporation, which through its affiliated companies provides health care and related services to communities and individuals in the intermountain region. Intermountain Health Care, Inc. is affiliated with Associated American Mutual Life Insurance Company and IHC, Inc. Retiree Welfare Benefit Trust through common management. IHC Health Services, Inc. is a Utah nonprofit corporation that provides medical and administrative services to the Organization. IHC Benefit Assurance Company, Inc. is a wholly owned, for profit, domestic life and health insurance company that insures certain non-emergency, out-of-panel encounters for enrollees of the Organization.

On June 18, 2001, the Organization entered into an Administrative Services Agreement with IHC Health Services, Inc. that memorialized a relationship that had existed since the

Organization's inception and the agreement's intended effective date is that date. Under the agreement, IHC Health Services, Inc. and the Organization provided various administrative services to each other at their fair value. Fair value is required to be determined according to usual accounting standards and practices.

The Organization provided marketing and administrative services under the terms of an Administrative Services Agreement with IHC Benefit Assurance Company, Inc. As compensation for services rendered, the Organization was paid a percentage, which may be adjusted annually, of IHC Benefit Assurance Company's premium. As of December 31, 2002, the percentage was 11 percent.

FIDELITY BOND AND OTHER INSURANCE

The minimum fidelity insurance suggested by the NAIC for a company of the Organization's size and premium volume was $1,250,000 to $1,500,000. The Organization was a named insured under a Basic Crime Policy issued to Intermountain Health Care, Inc., its subsidiaries, and affiliates. The policy provided fidelity coverage up to a single loss limit of $5,000,000 with a deductible of $100,000.

By attachment, the Organization was a named insured on various Intermountain Health Care, Inc. insurance policies. Directors' and officers' liability insurance had an aggregate limit of $25,000,000 with a $250,000 deductible. In addition, the Organization was a named insured under property, general liability, and workers' compensation policies.

PENSION, STOCK OWNERSHIP, AND INSURANCE PLANS

The Organization is a participant in a defined benefit retirement plan sponsored by Intermountain Health Care, Inc. The IHC Pension Plan provides a monthly benefit at retirement based on earnings and years of service. Employees vest in the plan after five years of service. Intermountain Health Care, Inc. pays the entire cost of the pension program by making annual contributions to the plan. The amount of contributions is determined with the assistance of the plan's actuaries. Federal law imposes certain minimum funding standards. An actuary must certify each year that the contributions to the plan meet these standards. An independent trustee that is responsible for the administration and management of the trust fund holds the assets of the plan.

The Organization participates in a defined benefit medical and life insurance plan sponsored by Intermountain Health Care, Inc. that provides medical benefits and basic and supplemental life insurance benefits to retirees and eligible dependents. Retirees who participate in these insurance benefits share in the cost of the premiums based on years of benefit service and on the extent of coverage. Intermountain Health Care, Inc. reserves the right to amend, replace, or terminate the plans and to reduce benefits or adjust the retiree share of the premium cost.

The Organization also participates in a 401(k) plan sponsored by Intermountain Health Care, Inc. Employee contributions to the 401(k) plan are matched up to a maximum of 3% of a participating employee's compensation.

STATUTORY DEPOSITS

Pursuant to U.C.A. § 31A-8-211, the Organization was required to maintain a statutory deposit of $6,523,476. The following securities were held on deposit in Utah for the benefit of all policyholders, claimants and creditors of the Organization.

Description	Par Value	Market Value
FHLB Bond	$2,000,000	$2,228,760
FNMA Bond	1,500,000	1,524,042
FHLMC Bond	1,000,000	1,007,813
FDIC Bond	2,231,011	2,227,385
Totals	$6,731,011	$6,988,000

INSURANCE PRODUCTS AND RELATED PRACTICES

Policy Forms and Underwriting

A concurrent market conduct examination compared the Organization's forms used in advertising materials and in the policyholder group files against the record of filed forms at the Department. No discrepancies were noted.

The Organization retained all risks other than losses incurred at hospitals. In general, the Organization's risk retention for losses incurred at hospitals was the first $1,000,000 of loss or losses incurred at an IHC hospital or the first $500,000 of loss or losses incurred at other hospitals by each covered person during an agreement year, plus 10 percent of losses in excess of the initial retention. Some policies were issued with unlimited lifetime benefits, which exposed the Organization to unlimited risk. The Organization and the Department are having continuing discussions to determine if and how the single risk limitation should be applicable to the Organization's policy contracts. (Refer to **REINSURANCE**)

Territory and Plan of Operation

As of the examination date, the Organization was authorized to conduct HMO business in the States of Utah, Idaho, and Wyoming. The Organization wrote large group, small group, and individual policies in Utah. Only large group policies were written in Idaho and Wyoming. As of September 30, 2002, the Organization's Medicaid risk contract with the Utah Department of Health was discontinued.

The Organization furnished health care services through arrangements with providers to enrollees in return for periodic payments. The Organization's plan of operations utilized

independent professional associations and clinic providers to provide medical services. Most hospital services were provided through the Organization's contract with its affiliate, IHC Health Services, Inc. The provider contracts, with the exception of an immaterial capitation arrangement with an intermediary, were on a fee-for-service or contractual fee basis.

The Organization marketed its products through individual agents appointed by one affiliated insurance agency, IHC Insurance Agency, LLC. and approximately 80 unaffiliated insurance agencies appointed by the Organization. The agencies worked closely with the Organization's in-house sales force to deliver products to clients.

Advertising and Sales Material

Sales materials were reviewed in a concurrent market conduct examination. The materials included packets given to potential clients and materials given to employees after enrollment into health plans. No material exceptions were noted.

Treatment of Policyholders

The Organization had written grievance procedures in place. The formal process for appealing an adverse benefit determination of a pre-service claim provided one mandatory review level, two possible voluntary review levels and the right to pursue civil action. The formal process for appealing an adverse benefit determination of a post-service claim provided two mandatory review levels, one voluntary review level, and the right to pursue civil action. Thirty-six appeals were made to the highest level of internal appeal in 2000, 50 in 2001 and 40 in 2002.

Complaint handling procedures and complaints were reviewed in the concurrent market conduct examination. The examination determined that the Organization maintains some control over policyholder complaints and that policyholders were being treated fairly. Forty complaints were filed with the Department in 1999, 29 in 2000, 21 in 2001, and 15 in 2002.

REINSURANCE

As of the examination date, an excess loss reinsurance agreement with Munich American Reassurance Company was in effect. The Organization's initial retention was the first $1,000,000 of loss or losses incurred at an IHC hospital or the first $500,000 of loss or losses incurred at other hospitals by each covered person during the agreement year. Reinsurance reimbursable amounts were based on the percentages shown below that were in excess of the initial retention:

- 90% of eligible losses, after certain reinsurance limitations, for transplant services performed in a hospital in which the reinsurer or the Organization had negotiated arrangements. The Organization's arrangements were required to be approved by the reinsurer.

- 50% for eligible losses, after certain reinsurance limitations, for transplant services performed in a hospital with which neither the reinsurer nor the Organization had negotiated arrangements and/or the Organization's arrangements were not approved by the reinsurer.

- 90% of eligible losses for services other than transplant services, after certain reinsurance limitations, for services performed in a hospital.

The maximum reinsurance indemnity payable under the agreement was calculated on the basis of $2,000,000 of coverage for each covered person.

U.C.A. § 31A-20-108 does not permit the Organization to expose itself to loss on any single risk in an amount exceeding 10% of its capital and surplus. The issuance of policies with unlimited lifetime benefits exposed the Organization to greater risk than permitted by this section. Policy lifetime benefit maximums range from $1,000,000 to unlimited with most policies limited to $2,500,000. The maximum retained single risk allowed based on examination capital and surplus was $8,152,802.

ACCOUNTS AND RECORDS

The Organization's accounting system utilized a centralized computer record processing system, supplemented by ancillary records maintained manually or on personal computers. An examination trial balance, as of December 31, 2002, was prepared from an electronic copy of the Organization's general ledger. Account balances were traced to annual statement exhibits and schedules without exception. Individual balance sheet account balances as of December 31, 2002, were examined in accordance with standards prescribed in the NAIC Financial Condition Examiners Handbook.

Accounts and records deficiencies included the following:

- The Organization's share of undistributed earnings of IHC Benefit Assurance Company, Inc. was not included in unrealized gains and losses as required by NAIC Accounting Practices and Procedures Manual ("APPM") SSAP No. 46, Section 12. Undistributed earnings were improperly reported on Annual Statement, Exhibit of Net Investment Income as earned and collected during the year.

- Uninsured accident and health plans pharmaceutical rebates receivable in excess of the amounts to be remitted to uninsured plans were not reported on the balance sheet as amounts receivable relating to uninsured accident and health plans and as a reduction to general expenses on the statement of operations as required by NAIC APPM SSAP No. 84, Section 13. The Organization improperly included the excess amounts as health care receivables on the balance sheet and as a reduction to claims expense on the Statement of Revenue and Expenses.

- Approximately $200,000 of claims unpaid as of December 31, 2002, were improperly included with premium deficiency reserves reported as additional policy reserves on Underwriting and Investment Exhibit, Part 2D rather than on Part 2A. In addition, the note relating to additional policy reserves incorrectly states the amount reported includes $ 0 premium deficiency reserve.

FINANCIAL STATEMENTS

The Organization's financial condition as of December 31, 2002, and the results of its operations during the twelve months then ended, as determined by examination, are reported in the following financial statements:

Balance Sheet as of December 31, 2002
Statement of Revenue and Expenses – January 1, 2002 through December 31, 2002
Surplus – January 1, 1998 through December 31, 2002

The accompanying Comments on Financial Statement are an integral part of these statements.

IHC Health Plans, Inc.
Balance Sheet
As of December 31, 2002

ADMITTED ASSETS

	Amount	Notes
Bonds	$ 97,510,468	
Common stocks	33,525,963	(1)
Cash and short-term investments	19,910,609	
Accident and health premiums due and unpaid	5,949,163	
Health care receivables	6,704,230	
Investment income due and accrued	1,078,560	
Amounts due from parent, subsidiaries and affiliates	664,079	
Amounts receivable relating to uninsured accident and health plans	1,503,352	
Electronic data processing equipment and software	1,943,011	
Aggregate write-ins for other than invested assets:		
Accrued additional retrospective premiums	2,653,988	
Total assets	$ 171,443,423	

LIABILITIES

Claims unpaid	$ 58,437,533	(2)
Accrued medical incentive pool and bonus payments	470,000	
Unpaid claims adjustment expenses	2,895,268	(3)
Aggregate policy reserves	2,829,695	
Premiums received in advance	4,778,683	
General expenses due or accrued	6,111,583	
Amounts withheld or retained by company for the account of others	606,789	
Amounts due to parent, subsidiaries and affiliates	124,030	
Liability for amounts held under uninsured accident and health plans	361,822	
Aggregate write-ins for other liabilities:		
Contingent liability for income taxes	13,300,000	
Total liabilities	89,915,403	
Gross paid in and contributed surplus	30,125,275	
Unassigned funds (surplus)	51,402,745	
Total surplus	81,528,020	(4)
Total liabilities and surplus	$ 171,443,423	

IHC Health Plans, Inc.
Statement of Revenue and Expenses
January 1, 2002 through December 31, 2002

	Amount	Notes
Net premium income	$680,115,061	
Change in unearned premium reserves and reserve for rate credits	577,592	
Fee-for-service	115,519	
Miscellaneous revenue	49,375	
Total revenue	680,857,547	
Hospital/medical benefits	418,064,953	(2)
Other professional services	35,905,341	
Emergency room and out-of area	36,574,378	
Prescription drugs	75,170,752	
Medical supplies	14,561,734	
Incentive pool and withhold adjustments	592,350	
Subtotal	580,869,508	
Net reinsurance recoveries (expenses)	(325,000)	
Total medical and hospital	581,194,508	
Claims adjustment expenses	11,671,647	(3)
General administrative expenses	57,087,320	
Increase in reserves for accident and health contracts	(399,941)	
Total underwriting deductions	649,553,534	
Net underwriting gain	31,304,013	
Net investment income earned	7,972,226	
Net realized capital gains or (losses)	(819,206)	
Net investment gains	7,153,020	
Contingent expense for income taxes	8,831,735	
Net income	$ 29,625,298	

IHC Health Plans, Inc.
Surplus
January 1, 1998 through December 31, 2002

	1998	1999	2000	2001	Per Exam 2002
Surplus December 31, previous year	$30,883,869	$24,700,303	$36,222,851	$66,180,585	$59,885,109
Increase (decrease) in contributed capital		2,000,000			
Net income (loss)	(5,182,143)	6,967,509	13,848,790	(1,311,114)	29,625,298
Net unrealized capital gains and (losses)	910,895	141,945	(1,234,694)	(1,589,907)	(2,380,124)
Change in non-admitted assets and related items	(1,912,314)	4,413,096	473,324	(5,696,510)	(5,602,247)
Cumulative effect of changes in accounting principles				2,302,055	
Aggregate write-ins for gains (losses) in surplus:					
Rounding	(4)	(2)			(16)
Reclassification to contributed capital		(2,000,000)			
Dissolution of IHC Insurance Agency			1,779		
Merger of IHC Care, Inc. and IHC Group, Inc.			16,868,535		
Net change in surplus for the year	(6,183,566)	11,522,548	29,957,734	(6,295,476)	21,642,911
Surplus, December 31, current year	$24,700,303	$36,222,851	$66,180,585	$59,885,109	$81,528,020

COMMENTS ON FINANCIAL STATEMENT

(1) Common stocks **$ 33,525,963**

The reported amount, $33,082,941, was increased by $443,022. The increase in the admitted value resulted from examination changes made in the concurrent examination of the Organization's subsidiary, IHC Benefit Assurance Company, Inc.

(2) Claims unpaid **$ 58,437,533**

The reported amount, $70,058,830 was decreased by $11,621,297 based on claims run-out through September 30, 2003. Actual claims incurred prior to January 1, 2003, paid in the first nine months of 2003 were $56,403,539. The remaining incurred but not reported (IBNR) claims were estimated to be $978,165. Miscellaneous liabilities were $1,055,829.

(3) Unpaid claims adjustment expenses **$ 2,895,268**

The Organization estimated that its liability for unpaid claims adjustment expenses was equal to approximately four percent of insured and uninsured claims unpaid exclusive of miscellaneous liabilities. Four percent was determined to be reasonable and adequate; therefore, the amount reported, $3,360,000 was decreased by $464,732, which is approximately four percent of the decrease in claims unpaid.

(4) Surplus **$ 81,528,020**

The Organization's surplus was determined to be $12,529,051 greater than reported. The following schedule identifies examination changes:

Description	Annual Statement Dr (Cr)	Examination	Change in Surplus Inc (Dec)
Common stocks	$33,082,941	$33,525,963	$ 443,022
Claims unpaid	70,058,830	58,437,533	11,621,297
Unpaid claims adjustment expenses	3,360,000	2,895,268	464,732
Total changes			12,529,051
Surplus per Organization			68,998,969
Surplus per examination			$81,528,020

U.C.A. § 31A-8-209(1) required the Organization to maintain minimum permanent surplus of $100,000 and minimum qualified assets in an amount not less than the total of the Organization's liabilities, minimum permanent surplus, and the company action level RBC as defined in U.C.A. § 31A-17-601(8)(b). The Organization had the required minimum permanent surplus and sufficient assets to meet the capitalization requirements as of December 31, 2002, as shown below:

Admitted Assets	$171,443,423
Liabilities	89,915,403
Minimum Permanent Surplus	100,000
Company Action Level RBC	50,099,574
Total	140,114,977
Assets in Excess of Minimum Requirement	$ 31,328,446

SUMMARY

Items of significance or special interest contained in this report are summarized below:

1. The previous examination decreased claims unpaid by $7,218,000. This examination decreased claims unpaid by $11,621,297. (SCOPE OF EXAMINATION – Status of Adverse Findings, Material Changes in the Financial Statement, and Other Significant Regulatory Information Disclosed in the Previous Examination)

2. U.C.A. § 31A-8-106 does not allow the Organization to engage, directly or indirectly, in any business other than that of an HMO and business reasonably incidental to that business. TPA business conducted by the Organization was considered by the Department to be reasonably incidental to HMO business; therefore, the Organization was in compliance with this section of the insurance code. (HISTORY – General)

3. In 1999, the IRS revoked the Organization's tax-exempt status under IRC § 501(c)(3) retroactive to January 1, 1987, and issued final adverse rulings denying tax-exempt status to Care and Group under IRC § 501(c)(3) retroactive to January 1, 1994. The Organization reapplied for tax-exempt status for each of the organizations. If the Organization is unsuccessful in qualifying for tax-exempt status for any of the three organizations, the Organization estimated that its exposure to loss in excess of the liability accrued was approximately $13,600,000 as of December 31, 2002. (HISTORY – General)

4. The sole member of the Organization is Intermountain Health Care, Inc. (HISTORY – Membership)

5. Beginning in 2002, officers of the Organization were no longer required to file conflict of interest statements. The requirement was reinstated in 2003. (HISTORY – Conflict of Interest Procedure)

6. Annual statement general interrogatory number 12 erroneously reported that the Organization keeps a complete permanent record of the proceedings of its board of directors and all subordinate committees. Quality Assurance Committee meeting minutes were not kept as required by Article V of the Organization's Amended Bylaws. (HISTORY – Corporate Records)

7. There was no indication in the board or committee minutes that the board or a subcommittee took any actions with regard to compensation of trustees, officers or employees. (HISTORY – Corporate Records)

8. Care and Group merged with and into the Organization pursuant to Articles of Merger, dated October 20, 2000, approved by the Department. (HISTORY – Acquisitions, Mergers, Disposals, Dissolutions and Purchases or Sales through Reinsurance)

9. The Organization is affiliated with numerous entities within the insurance holding company system. Many of these entities were not reported on Annual Statement, Schedule Y, Part 1 or in Form B filings with the Department. (AFFILIATED COMPANIES)

10. The issuance of policies with unlimited lifetime benefits exposed the Organization to greater risk than permitted by U.C.A. § 31A-20-108. (REINSURANCE)

CONCLUSION

Assistance and cooperation extended during the course of the examination by officers, employees, and representatives of the Organization are acknowledged. In addition to the undersigned, Faaru Laufiso, Financial Examiner, participated in the examination. John Kay, CFE, CIE, Assistant Chief Examiner, supervised the examination.

Respectfully submitted,

C. Kay Anderson

C. Kay Anderson, CFE
Examiner-in-charge
Representing the Utah Insurance Department